

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

5368

63-021983

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>FILED MAY 27 1963</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Saint Louis</b>		c. CITY OR TOWN <b>Saint Louis</b>	
Length of stay in 1b <b>Years</b>		Inside Limits <b>Yes</b> <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>Deaconess Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>4370 Delor</b>	
3. NAME OF DECEASED (Type or print) <b>AKA Robert S. Mills</b> <b>ROBERT SAMUEL MILLS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Stationary Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Water Dept</b>	
11. BIRTHPLACE (City and state or country) <b>Gedat Rapids, Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Robert D. Mills</b>		13b. MOTHER'S MAIDEN NAME <b>Cora Dickinson</b>	
14. NAME OF HUSBAND OR WIFE <b>Rose M. Mills</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Rose M. Mills, St. Louis, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatous</b> <b>Carcinoma of Larynx</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <b>161x</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>3 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>12:47</b> a.m. <b>7:00</b> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>St. Louis Co., Mo.</b>	
21. I attended the deceased from <b>12:47 p.m.</b> to <b>May 17, 63</b> and last saw him alive on <b>May 17, 63</b> . Death occurred at <b>12:47 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deceased or He) <b>Robert S. Mills</b>	
22b. ADDRESS <b>415 Lucade Bldg</b>		22c. DATE SIGNED <b>5/19/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-20-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>Hoffmeister Colonial</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 20 1963</b>	
ADDRESS <b>6464 Chippewa</b>		26. REGISTRAR'S SIGNATURE <b>Robert Smith, M.D.</b>	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lee C. Branson

Licensed Embalmer No. 4764

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.